Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

K MATHEW WARNOCK II MD
7401 S MAIN STREET
HOUSTON TX 77030-4509

Respondent Name

NETHERLANDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-4983-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denied for timely however proof of timely filing attached."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has denied reimbursement for the medical treatment underlying the disputed charge because the requestor did not timely submit its bill for services rendered to the carrier. The requestor alleges that the bill was originally submitted to the wrong carrier. While the requestor has correctly noted that HB 1005 mandates that the correct carrier should audit a disputed bill without regard for the 95-day deadline when the bill was originally submitted to the wrong carrier this provision does not apply in the present case. As noted in Texas Labor Code Section 408.0272(b)(1) and Division Rule 133.20(b), the provider must submit proof of the initial submission (to the wrong carrier) when submitting the bill to the correct carrier. The requestor has not provided any documentation to show that the bill was originally submitted to the wrong carrier within the required 95-day timeframe. Consequently, no additional reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P. O. Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2010	99213	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 8, 2011
   - 863-101 – THE TIME LIMIT FOR FILING HAS EXPIRED. THE STATUTE OF LIMITATIONS HAS EXPIRED. UMD RECOMMENDS $0.00

   Explanation of benefits dated April 12, 2011
   - 859-000 – PAYMENT DENIED/REDUCED FOR ABSENCE OF OR EXCEEDED REFERRAL. NOT APPROVED TREATMENT. UMD RECOMMENDS $0.00
   - 900-025 – THE STATE SPECIFIED TIME LIMIT FOR SUBMITTING A MEDICAL BILL HAS EXPIRED, THEREFORE THE SERVICE IS NOT REIMBURSED.
   - 901 – RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLIAM WAS PROCESSED PROPERLY.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027 and 28 Texas Administrative Code §102.4?
3. Did the requestor waive their right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Requestor states that they originally sent bill to America First Insurance and that on January 19, 2011 the requestor spoke to adjustor Heather Jones at 503-946-4057 who stated claim now should go to Nova Med, however, America First Insurance does not meet the criteria of one of the entity types as described in Texas Labor Code §408.0272 . Therefore, Texas Labor Code §408.0272 does not apply to the service in dispute, for that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the Requestor finds one copy of a medical bill with printed date 10/20/10 and two Explanation of Benefits dated, February 8, 2011 and April 12, 2011. No documentation was found to sufficiently support that a medical bill was submitted to the correct insurance carrier within 95 days from the date the services were provided.
3. In accordance with Texas Labor Code §408.027, the Requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 18, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.